

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/24/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN 47713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was the Post Survey Revisit (PSR) to the Investigation of Complaint IN00083702 completed on January 12, 2011.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00085197 and IN00085238 completed on February 2, 2011.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00087956.</p> <p>Complaint IN00083702 - Corrected.</p> <p>Survey dates: March 23 and 24, 2011</p> <p>Facility number: 000152 Provider number: 155248 AIM number: 100267510</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 9 Medicaid: 65 Other: 8 Total: 82</p> <p>Sample: 11</p> <p>Golden Living Center-Brentwood was found to be in compliance with 42 CFR Part 483 Subpart B</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/24/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN 47713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Continued From page 1 and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00083702. Quality review 3/29/11 by Suzanne Williams, RN			{F 000}			